American Medical Association
Physicians dedicated to the health of America

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# Statement

of the

American Medical Association

to the

Practicing Physician Advisory Council

RE: Physician Payment Update Formula
Pay for Performance Initiatives

**March 7, 2005**

Division of Legislative Counsel
202 789-7426

# AMA RECOMMENDATIONS FOR PPAC

**The AMA urges the Practicing Physicians Advisory Council to recommend that—**

- **CMS use its administrative authority to remove Medicare-covered, physician-administered drugs and biologics from the physician payment formula, retroactive to 1996.**

- **As CMS develops and implements pay for performance program, these programs should remain in alignment with certain principles and guidelines developed by the AMA that are attached to our written statement; and**

- **CMS ensure that implementation of any quality improvement/pay for performance programs is premised on establishment of a reliable, positive Medicare physician payment formula.**

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RE: Physician Payment Update Formula Pay for Performance Initiatives

March 7, 2005

The American Medical Association (AMA) appreciates the opportunity to submit this statement to the Practicing Physicians Advisory Council (PPAC or the Council) concerning the physician payment update formula and pay for performance quality improvement initiatives.

The AMA appreciates the efforts of the Centers for Medicare and Medicaid Services (CMS) to address problems inherent in the fatally flawed physician payment update formula. As you know, the flaws in the Medicare physician payment formula led to a 5.4% payment cut in 2002, and additional cuts in 2003 through 2005 were averted only after Congressional intervention. These short-term Congressional interventions will expire next year, however, and the Medicare Trustees have projected that physicians and other health professionals face pay cuts totaling 31% over the next eight years. Payments for cataract surgery, for example, will fall form an average of $684 in 2005 to an average of $469 in 2013.

These reductions are not cuts in the rate of increase, but are actual cuts in the amount paid for each service, resulting in a reduction in physician payment rates of nearly a third. They come at a time when even by Medicare's own conservative estimate, physician practice costs are expected to rise by 19% and when many physicians face far larger increases due to skyrocketing medical liability insurance premiums. They also follow more than a decade of Medicare cost constraints that held payment increases to 18% between 1991 through 2005, despite the government's conclusion that practice costs had increased by 40% over the same time period. Physicians simply cannot absorb these draconian payment cuts and, unless the Administration and Congress act, it is difficult to see how they can avoid discontinuing or limiting the provision of services to Medicare patients.

A physician access crisis is looming for Medicare patients. While the MMA has made significant strides in improving the overall system for Medicare beneficiaries, including broad-scale improvements for care furnished to patients in rural areas as well as important new benefits, these critical improvements must be supported by an adequate payment

structure for physicians' services. There are already some signs that access is deteriorating, including a 2.5% reduction in the number of new patient visits per enrollee in 2003, as reflected in claims data for that year. Physicians are the foundation of our nation's health care system, and continual cuts (or even the threat of repeated cuts) put Medicare patient access to physicians' services (as well as drugs and other services they prescribe) at risk and threaten to destabilize the Medicare program and create a ripple effect across other programs, as well. Indeed, Medicare cuts jeopardize access to medical care for millions of our active duty military family members and military retirees because their TRICARE insurance ties its payment rates to Medicare.

**The Administration and Congress must take immediate action to replace the SGR with a system that keeps pace with increases in the cost of practicing medicine. While we greatly appreciate the short-term reprieves achieved by CMS and Congress in recent years, a long-term solution that implements a new payment update system that keeps pace with increases in the cost of practicing medicine is needed now. Indeed, the temporary fixes have led to even deeper and longer sustained cuts because Congress recouped the cost of temporarily blocking the severe cuts in physician payments in the out-years. Without administrative and congressional action to implement a long-term solution now, repeated interventions will be required to block payment cuts that jeopardize continued access to high quality care for the elderly and disabled.**

## ADMINISTRATIVE ACTION NEEDED TO REMOVE DRUGS FROM THE SGR

Apart from the inherent problems in the physician payment formula, there are other problems with implementation of the SGR that seriously threaten patient access and inequitably affect payment updates due to factors that are beyond physicians' control. The Administration has the authority to take additional action to help ease these implementation problems and lead the way for Congressional intervention. **Specifically, we urge the Council to continue to recommend that CMS use its administrative authority to remove Medicare-covered, physician-administered drugs and biologics from the physician payment formula, retroactive to 1996.**

### *CMS Authority to Remove Drugs from the SGR*

As discussed above, Medicare payments to physicians are reduced when actual Medicare spending for physicians' services exceeds a pre-determined spending target (the SGR). When CMS calculates actual spending on physicians' services, it includes the costs of Medicare-covered prescription drugs administered in physicians' offices. Although the physician's administration of the drug is clearly a physician service that by statute must be included in the pool, the drugs themselves are not "physicians' services" and drugs are not paid under the Medicare physician fee schedule. Thus, it is inconsistent to include drugs in the calculation of expenditures in the SGR methodology. In fact, in an interim final rule issued in December 2002 (on the application of inherent reasonableness to Medicare Part B services), CMS chose to exclude drugs from the definition of "physicians' services." To include drugs as a "physicians' service" for certain purposes, but not for others, is

inconsistent and inequitable. Indeed, this policy has been questioned by key Congressional leaders, who have repeatedly requested that CMS remove drugs from the SGR baseline. In addition, more than 240 House members and more than 70 Senators have signed various letters asking CMS to take this action.

Nothing in the statute requires part B drugs to be included in the SGR formula. It has simply been a CMS decision to include drugs and CMS could easily make a different decision to exclude drugs, while still effectively implementing the statute written by Congress. Specifically, CMS has the legal authority to revise the definition of services to allow drugs to be fully removed from computation of actual and allowed expenditures back to the SGR base period, as discussed in a legal memorandum (drafted by Terry S. Coleman, a former Chief Counsel and Deputy Administrator of the Health Care Financing Administration) provided to CMS and Congress by the AMA.

*CMS Should Remove Drugs from the SGR*

A new physician payment formula that reflects the cost of practicing medicine is desperately needed, but current budget deficit projections will make it extremely difficult for Congress to take the steps that are needed to implement such a formula. **The Administration and CMS must reduce the price tag and help pave the way for an appropriate long-term solution by removing drugs from the SGR pool, retroactive to 1996. In fact, Secretary Leavitt has indicated to the Senate Finance Committee that (in accordance with current estimates) removing drugs from the SGR would trigger a 3.7 percent update in 2006. Even more fundamentally, removing Part B drugs from the SGR formula would nearly eliminate all of the impending cuts to physicians — every 5% cut for 7 consecutive years would be wiped out by taking this one simple action.**

Pharmaceutical companies, not physicians, control the cost of drugs and receive the bulk of all Medicare dollars spent on these drugs. Further, pharmaceutical companies and United States policy, not physicians, control the introduction of new drugs into the market place, and drug expenditures are continuing to grow at a very rapid pace. Over the past 5 to 10 years, drug companies have revolutionized the treatment of cancer and many autoimmune diseases through the development of a new family of biopharmaceuticals that mimic compounds found within the body. The lives of millions of disabled and elderly Americans have been extended and improved as a result. But such achievements do not come without a price. Drug costs of $1,000 to $2,000 per patient per month are common and annual per patient costs were found to average $71,600 a year in one study.

Further, between the SGR's 1996 base year and 2003, the number of drugs included in the SGR pool rose from 363 to 430. Spending on physician-administered drugs over the same time period rose from $1.8 billion to $7.7 billion, an increase of 318% per beneficiary compared to an increase of only 46% per beneficiary for actual physicians' services. As a result, drugs have consumed an ever-increasing share of SGR dollars and have gone from 3.7% of the total in 1996 to 9.8% in 2003.

This lopsided growth lowers the SGR target for real physicians' services, and, according to the Congressional Budget Office, annual growth in the real target for physicians' services will be almost a half percentage point lower than it would be if drugs and lab tests were not counted in the SGR. As 10-year average GDP growth is only about 2%, even a half percent increase makes a big difference. Thus, including the costs of drugs in the SGR pool significantly increases the odds that Medicare spending on "physicians' services" will exceed the SGR target. Ironically, however, Medicare physician pay cuts (resulting from application of the SGR spending target) apply only to actual physicians' services, and not to physician-administered drugs, which are significant drivers of the payment cuts.

Although growth in drug expenditures appears to have slowed somewhat in 2004, Medicare actuaries predict that drug spending growth will continue to significantly outpace spending on physicians' services for years to come. This is a realistic assumption. In 2003, MedPAC reported that there are 650 new drugs in the pipeline and that a large number of these drugs are likely to require administration by physicians. In addition, an October 2003 report in the *American Journal of Managed Care* identified 102 unique biopharmaceuticals in late development and predicted that nearly 60% of these will be administered in ambulatory settings. While about a third of the total are cancer drugs, the majority are for other illnesses and some 22 medical specialties are likely to be involved in their prescribing and administration.

The development of these life-altering drugs has been encouraged by various federal policies including expanded funding for the National Institutes of Health and streamlining of the drug approval process. To its credit, the Administration has made acceleration of the pace of drug development one of its goals and has adopted a number of policies that spur such development. Last June, for example, CMS and the National Cancer Institute announced a collaborative effort to improve the process for bringing new anti-cancer drugs to patients. In July, the Food and Drug Administration announced that it will create a new oncology office to further facilitate the approval process for these drugs. In August, CMS launched a new Council on Technology and Innovation that Administrator McClellan announced is intended to ensure that Medicare "beneficiaries have access to valuable new medical innovations as quickly and efficiently as possible." The AMA shares and applauds these goals. However, it is not equitable or realistic to finance the cost of these drugs through cuts in payments to physicians.

It is simply bad public policy to penalize physician payments when certain physicians prescribe needed life-saving drugs. Yet, the current formula creates disincentives to prescribe these drugs by cutting all physicians' pay when certain physicians prescribe Part B drugs.

**Accordingly, we recommend that the Council continue to urge CMS to remove drugs from the SGR pool, retroactive to 1996. With payment cuts slated to begin in 2006, it is critical for the Administration and CMS to act as soon as possible.**

## PAY FOR PERFORMANCE INITIATIVES

*Pay For Performance Initiatives Need A Stable Medicare Physician Payment System*

Last month, CMS announced a new "pay for performance" initiative that will pay large physician group practices for meeting certain performance targets adopted by CMS relating to improved health outcomes and costs savings, and stated that the Administration is committed to rewarding innovative approaches to get better patient outcomes at lower costs. **The AMA is also committed to quality improvement and we support innovative efforts, such as the use of pay for performance strategies that are primarily designed to improve the effectiveness and safety of patient care. In fact, over the last five years, the AMA has spent over $5 million in convening the Physician Consortium for Performance Improvement for the development of performance measurements and related quality activities. Physicians will be hard pressed, however, to undertake quality initiatives that require certain costly resources, such as IT, if they are facing steep payment cuts. Therefore, it is critical to replace the flawed physician payment formula to maximize physicians' capabilities to participate in these performance for performance initiatives.**

With projected Medicare payment cuts of more than 30 percent between 2006 and 2012, many physician practices are heavily focused on simply keeping their doors open to patients. In addition, due to recent cuts and the expectation of more to come in 2006 and subsequent years, many physicians have already been forced to delay investment in maintaining and improving office facilities, staff and equipment. Others have had to cover overhead by seeing more patients and shortening the time of each patient visit.

Often participation in pay for performance initiatives can require significant financial investment in expensive new information technology or increased human resources. It is difficult to fathom how physician office practices will be able to make such a financial investment in light of current struggles to absorb past and projected steep Medicare pay cuts. Additional funding to implement quality improvement initiatives in physicians offices would be critical for a successful outcome.

The AMA also has strong concerns about any pay for performance initiatives that would seek to maintain budget neutrality by improving payments to some physicians while reducing payments to others that are already in financial jeopardy and unable to commit needed financial and/or human resources to participate in the initiative. To further complicate matters, effective and appropriate quality measures vary among specialties and some--such as patient tracking--that are most easily implemented may not be relevant for all specialties. Thus, the feasibility of participating in a quality improvement program may vary significantly among medical specialties, and it is not clear that all specialties would have a realistic opportunity to compete for quality-related payments.

**Finally, the AMA is concerned that while pay for performance initiatives could eventually improve quality and accrue overall savings to the health care system, these**

**programs in the early years likely would increase utilization of physician services.** For example, during his May 11, 2004 appearance before the House Ways and Means Health Subcommittee, CMS Administrator, Dr. Mark McClellan, suggested that one of the agency's quality improvement projects, the Chronic Care Improvement Project, "may actually increase the amount of (patient-physician) contact through appropriate office visits with physicians." Additional care and patient visits to achieve improved quality, while applauded, would cause Medicare spending on physician services to exceed the SGR spending target, thereby triggering still more Medicare physician pay cuts and compounding the problems physician practices are experiencing due to already strained office budgets.

**The AMA thus urges the Council to recommend that CMS ensure that implementation of any quality improvement programs is premised on establishment of a reliable, positive Medicare physician payment formula. Expecting physicians to make investments in new information technology and participate in quality improvement initiatives before there is a solution to the payment update problem defies logic. Quality improvement initiatives can flourish only if payment cuts are permanently eliminated and replaced with at least modest updates.**

*AMA Pay for Performance Principles and Guidelines*

On March 2, 2005, the AMA unveiled a new set of principles and guidelines for the formation and implementation of pay-for-performance programs. Pay-for-performance programs may serve as a positive force in the health care industry if the programs are designed primarily to improve the effectiveness and safety of patient care. Fair and ethical pay-for-performance programs are patient-centered and assess physician performance with evidence-based measures.

As the pay-for-performance concept becomes more commonplace, the physician community will work to ensure pay-for-performance programs are positively structured and appropriately applied. **We urge the Council to recommend that as CMS develops and implements pay for performance program, these programs should remain in alignment with the following principles, which are further discussed in attachments hereto:**

- Ensure quality of care;
- Foster the relationship between patient and physician;
- Offer voluntary physician participation;
- Use accurate data and fair reporting; and
- Provide fair and equitable program incentives.

Health plans, large employers, Medicare, and some members of Congress are supporting the pay-for-performance concept. Both private and public sector organizations have started offering incentive payments to physicians based on an appraisal of their performance.

The primary goal of any pay-for-performance program must be to promote quality patient care. Some so-called pay-for-performance programs are a lose/lose proposition for patients and their physicians with the only benefit accruing to health insurers. We believe that pay-

for-performance programs done properly have the potential to improve patient care, but if done improperly can harm patients.

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We appreciate the opportunity to provide our views, and look forward to working with the Administration, CMS and Congress to ensure quality improvements for our patients, along with an adequate and reliable Medicare physician payment system that keeps pace with the cost of practicing medicine.